United States Senate
COMMITTEE ON FINANCE
WASHINGTON, DC 20510–6200

April 2, 2019

VIA ELECTRONIC TRANSMISSION

Director Yvette Doan
Mentor Oregon
11010 SE Division Street, Suite 300
Portland, OR 97226

Dear Ms. Doan,

We write concerning disturbing news involving The MENTOR Network in Oregon (Mentor Oregon). Earlier this year, *The Oregonian* reported that the company closed an adult group home serving individuals with intellectual and developmental disabilities (I/DD) after the Oregon Department of Human Services (Oregon DHS) moved to revoke the home's license following an investigation revealing appalling accounts of substandard care.[1] This investigative report outlined a litany of abuses and neglect by Mentor Oregon staff in 2017 toward a client unable to walk or communicate.[2]

Our staffs subsequently learned that additional state-wide impositions of conditions have been issued by the State covering Mentor Oregon's 24-hour group homes. This action follows neglectful care toward three additional clients, including one which has led to an ongoing protective service investigation involving a death.

The Senate Committee on Finance has primary and sole jurisdiction over the Medicaid program. In this role, the Committee has the responsibility to ensure the appropriate use of federal dollars and that Medicaid beneficiaries receive the high-quality health care to which they are entitled. As a private entity contracting with the States to provide medical assistance for which Federal Medicaid funds have been received, Mentor Oregon's Medicaid contracts and 24-hour residential services fall within this purview.

Furthermore, relating to the company's performance record, the Committee released an October 2017 report detailing a two and a half-year investigation into foster care privatization

[1] Zarkhin, Fedor, *The Oregonian* (Jan. 10, 2019), https://www.oregonlive.com/pacific-northwest-news/2019/01/neglect-victim-smelled-of-rotting-flesh-caregivers-say-as-state-shutters-home-for-people-with-disabilities.html.
[2] *Id.*

and the increasing practice of States contracting with private entities to protect our nation's most vulnerable children.[3] This report analyzed The MENTOR Network as a case study (herein referred to as Mentor) and found that, over a ten-year period, approximately 70 percent of children's deaths under Mentor's care were "unexpected," despite the company's own claim that it serves "significantly more children and youth with heightened risk factors."[4] Additionally, Mentor did not always conduct an internal investigation into deaths that were unexpected. The Committee also found that Mentor was often out of compliance with its own guidelines governing background checks of those who care for foster children or those who are routinely in homes where foster children are placed.[5]

It is incumbent upon Federal and state governments to conduct oversight to ensure that adults and children with I/DD receive high-quality care. Therefore, we ask that you provide the following information to the Committee **no later than April 30, 2019**:

1. According to Mentor Oregon's website, the company provides the following services: brokerage services, I/DD services for adults and children, as well as services for those with brain or spinal cord injuries. For each service provided, please answer the following questions:

    a. How long has the company provided such services in the State?
    b. In which locations does Mentor Oregon provide these services?
    c. Which state entity is the regulator for these services?
        i. How often is Mentor Oregon audited or reviewed by this regulator?
        ii. Is there advance notice prior to the review?
    d. Please provide a copy of the most recent contract with the State for each service.

2. Copies of every assessment, investigation, or performance review of all Mentor Oregon facilities issued by the State, or its oversight contractors, from January 2013 to the present.

3. Copies of each mandatory report concerning suspected abuse (e.g. Level IV reports[6]) since January 2013, as well as any enforcement actions associated with an investigation by the State or its oversight contractors.

4. Please indicate if there are any current or pending State investigations concerning Mentor Oregon staff or clients. If there is such an investigation, please include the date the investigation began and the issues and allegations involved.

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[3] Hatch, Wyden Respond to Significant Need to Improve Government Oversight Following Foster Care Investigation, U.S. Senate Committee on Finance (Oct. 17, 2017), https://www.finance.senate.gov/chairmans-news/hatch-wyden-respond-to-significant-need-to-improve-government-oversight-following-foster-care-investigation.

[4] An Examination of Foster Care in the United States and Use of Privatization, Committee on Finance (Oct. 2017), https://www.finance.senate.gov/imo/media/doc/An%20Examination%20Of%20Foster%20Care%20In%20The%20United%20States%20And%20The%20Use%20Of%20Privatization.pdf.

[5] *Id.*

[6] In the foster care setting, a Level IV incident report captures the agency's most serious incidents of injury, assault, abuse or other similar events. *Id.* at 20.

5. The locations and addresses of each Mentor Oregon 24-hour residential I/DD group home, including a description of the services provided since January 2013. For each group home, please provide:

    a. The names of the Facility Manager, Program Supervisor, Program Director and Area Director associated with each facility since January 1, 2013, as well as their tenures in both their current positions and with Mentor Oregon.
        i. For each staff member listed, have any of the individuals been previously the subject of an investigation for alleged abuse or neglect?
        ii. Has each staff member passed a comprehensive background check prior to being employed by The MENTOR Network?
    b. The number of clients served for each calendar year.
    c. The number of staff employed by each facility for each calendar year.
    d. Ratios of staff employed by each facility to clients served for each calendar year.
    e. The total amount each facility received in Medicaid reimbursements for services provided for each calendar year.
    f. Documentation that staff have completed all required trainings.
    g. All incident reports at any level associated with the facility.

Please answer each question on a question-by-question basis indicating which question you are responding to. If you have any questions, please contact Caitlin Soto of Chairman Grassley's staff, or Ian Nicholson and Dave Berick of Ranking Member Wyden's staff, at (202) 224-4515. Thank you for your prompt attention to this matter.

Sincerely,

Chuck Grassley

Chuck Grassley
Chairman
Senate Finance Committee

Ron Wyden

Ron Wyden
Ranking Member
Senate Finance Committee